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FOCUS

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Putting Patients Over Profits in Health Care

New York's Lt. Governor Crusades Against Dangerous Practices by Care Providers and Insurance Companies

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Several Programs Are Exposing African Americans to New Academic Opportunities While They Learn Golf, Hockey, Soccer, and Gymnastics

Creating Health Care Jobs, But at Low Wages

Most New Employment Generated by the Fast Growing Health Care Industry Will Be Low Skill, Low Wage Jobs

TRENDLETTER **PERSPECTIVE**

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The Health Care Industry: More Jobs, Less Care

The health care industry is undergoing significant changes that will have far-reaching implications for both workers and patients. Faced with increasing demands for care as the baby boom generation ages and the pressures to cut the costs of doctor and hospital bills, there is concern that the health care providers are compromising on the quality of care patients receive. Meanwhile, as hospitals limit patient stays, requiring more home care, the health care industry is undergoing a dramatic restructuring that is resulting in the creation of new jobs. Many of these jobs are at lower wages. Employment projections indicate that the fastest growing occupations over the next decade will be in health industries.

At the Joint Center, we see both of these developments as critical to the future well-being of African Americans. New employment opportunities are desperately needed in our communities in order to improve the economic conditions of individuals and families. If the health industries can provide those opportunities, we need to know how to capture them.

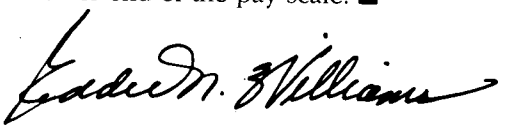
But we are also concerned about the impact of these developments on our physical and mental health. The Joint Center's recently released publication on health care, *Achieving Equitable Access*, shows that African Americans continue to suffer from unequal access to health care. Changes in the health care delivery and financing systems could jeopardize any further progress toward equity.

This edition of *FOCUS* contains two features that address the issue of abuses by health care providers and insurance companies and the expanding employment opportunities in the health care industry. "Putting Patients Over Profits in Health Care," by New York Lieutenant Governor Betsy McCaughey-Ross, focuses on protecting the quality of health care, making health insurance affordable and sustaining the search for more cures. McCaughey-Ross, who holds a Ph.D from Columbia University, began her career as a public official with more than twenty years experience as a public policy expert, college professor, and author.

McCaughey-Ross stated that HMOs have worked financial disincentives into many physicians' compensation agreements to deter them from referring patients to specialists, ordering diagnostic tests, and keeping patients in the hospital longer than guidelines prescribe. Emphasizing the dangerous trend of limiting hospital stays, McCaughey-Ross charged that some health care providers are making mastectomies an outpatient procedure to cut costs.

She also warned that cost-cutting measures by some health care operators are diverting funds away from teaching hospitals and research for new cures. McCaughey-Ross supports legislation requiring insurers to provide 48 hours of hospital care following mastectomies. She also backs a measure that would compel insurers to disclose the financial incentives used to induce doctors to give less care.

The health care industry will add millions of new jobs to the U.S. economy for the foreseeable future. This job growth is particularly important to African Americans who are about 11 percent of the labor force overall, but 16 percent of the hospital workforce and 24 percent of all nursing home workers. The feature, "Creating New Health Care Jobs, But at Low Wages," notes that as hospitals and HMOs expand their nursing home facilities, they shift care from physicians and other well-paid and highly trained care providers to less skilled and lower-paid workers. Thus most of the new health care jobs available to African Americans will be among lower-skilled occupations that are on the lower end of the pay scale. ■



PRESIDENT

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Putting Patients Over Profits in Health Care

New York's Lt. Governor Crusades Against Dangerous Practices by Care Providers and Insurance Companies

by Betsy McCaughey-Ross

The following speech excerpt by New York lieutenant governor McCaughey-Ross focusing on abuses by health care providers and insurance companies was presented at the Joint Center's Economic Forum on Job Creation Within Health Industries, which was held in Washington, D.C. on November 20. McCaughey-Ross holds a Ph.D. from Columbia University and has taught at Columbia University and Vassar College. She has also been a senior fellow at The Manhattan Institute for Policy Research and is the author of several books.

Recently, I went to look at colleges with my oldest daughter. We were in a taxi when the driver, whose name was Dominic, told me that he had a daughter the same age who was sick and he didn't have health insurance. His employer didn't offer it and he was worried. Like Dominic, 41 million Americans and 2.5 million New Yorkers are uninsured. Yet 85 percent of these people go to work every day, mostly for small businesses.

Republicans and Democrats need to work together in Congress to make health insurance more affordable. The bipartisan Kassebaum-Kennedy Act, which was signed into law recently, solves a small part of the health insurance problem. It makes health insurance portable, but it does little to make it affordable.

Bonuses for Not Referring Specialists

The second step toward better health care is to make health insurance safer. Abuses by Health Maintenance Organizations (HMOs) are the single largest health care problem in the United States. You are affected by this problem whether or not you signed up with an HMO yourself. A federal law is needed to protect patients against HMOs that discharge them from the hospital too soon, that pay their doctor a secret bonus for not referring them to a specialist, and that prohibit their doctor from telling them the whole truth about the care they need.

Managed care offers enormous advantages to cost-conscious consumers and to employers striving to control benefit costs. But if we are going to encourage people to enroll in HMOs, we have to make sure that HMOs are putting patients ahead of profits and that people get all the information they need to choose a safe health plan. This is especially important to elderly Americans.

Nine percent of Medicare recipients are enrolled in managed care plans, and they are especially vulnerable to abuses. Recently I noticed several new dark spots, lesions, on my skin. When that happens the smart thing is to go to the doctor right away and get them checked. My dermatologist assured me that most of the spots were nothing to worry about, but one dark brown lesion on my foot concerned her, so she removed it to send it out for a biopsy. Then she said to me, "You're lucky you have the insurance you do because some HMOs have told me that if I send a skin lesion out for a biopsy and the test comes back negative—no basal cells, no cancer—the insurance company won't pay for the test." That's like telling a doctor that if a woman has a mammogram and no cancer is found, the test isn't covered.

Some of the large, for-profit HMOs withhold between 10 and 25 percent of a physician's compensation and give it back only if the physician meets stringent targets for limiting how many referrals to specialists, how many diagnostic tests, and how many days in the hospital his patients get. Doctors report that it's virtually impossible to get that "withhold" back at the end of the year. It means that what a doctor prescribes for a patient comes out of a doctor's own pocket at the end of the year. It sets up a conflict of interest between you and the person you really need in your corner when you're sick—your doctor. You ought to know before you choose a health plan whether the insurer is going to withhold part of your doctor's salary for referring you to a specialist or pay your doctor a bonus for not referring you.

As Health and Human Services Secretary Donna Shalala has said, "No patient should have to wonder whether their doctor's decision is based on sound medicine or financial incentives." HMOs should have to disclose in plain language, in all their promotional literature, whether they are going to pay your doctor a secret bonus for not referring you to a specialist or secretly penalize your doctor for ordering a test.

That's why I am urging everyone, Democrats and Republicans alike, to support the Family Health Care Fairness bill. It is a disclosure bill sponsored by a physician, Congressman Charlie Norwood (R–Ga.). We need this bill because it will compel insurers to level with you about the financial incentives they use to reward doctors for giving less care and penalize doctors financially for giving patients the care they need. Disclosure is the most fundamental principle of the American marketplace. You walk into a supermarket and buy a can of soup—the ingredients are on the label. You pick up a pack of cigarettes—the warning is on the side of the pack. When you buy a health plan, you should be able to get the facts too.

Continued on page 4

Ms. McCaughey-Ross is the lieutenant governor of New York.

Continued from page 3

Drive-Through Mastectomies

Some insurers are cutting costs by making mastectomies, the surgical amputation of a woman's breast, an outpatient procedure. Women, even those 65 and over, are discharged from the hospital hours after surgery, and husbands and other family members are expected to monitor bleeding and empty drainage bags hanging from the wound. More than 3,000 elderly woman endured mastectomies as outpatients last year alone. Advocates for outpatient mastectomies cite cost savings. A mastectomy with a customary three-night hospital stay costs over $6,000, while an outpatient procedure saves about 75 percent of that. But it doesn't save a woman from the danger of hemorrhaging the first night or from out-of-control pain or from psychological trauma.

That's why I am supporting the efforts of state lawmakers in New York to enact a 48-hour bill for breast cancer patients—a law requiring insurers to provide 48 hours of hospital care following a mastectomy. And I am urging all members of the New York congressional delegation, Democrats and Republicans alike, to support Congresswoman Rosa De Lauro's (D-Conn.) federal 48-hour bill, because health care is too important to let partisanship get in the way.

Only months ago Congress enacted a 48-hour law to give every newborn a safe start in life. Insurers have slashed hospital stays and costs by discharging newborns as soon as 8 hours after birth, before doctors could be sure they are healthy. In fact, the American College of Obstetricians and Gynecologists reported that women in labor were being told to wait in the hospital parking lot as long as they can stand it, so the clock wouldn't start ticking on the time their HMOs allowed them to be in the hospital.

But how many 48-hour bills will we have to pass to stop insurers from putting profits ahead of patients? Are we going to fight this battle again and again on every medical front? Ultimately, the answer is not to legislate minimum hospital coverage for each and every medical procedure. Lawmakers need to provide overall protection against insurance abuses, and stop insurers from interfering in the decisions your doctor makes about your care. We in New York are responding. So are other states. Some 400 bills were introduced into state legislatures this year because of horror stories of care denied or delayed. But we in state government can do only so much.

Opting for Cheaper, More Painful Drugs

Citizens should also know about restrictions on their doctor's decision making and who is making the decisions about their care. For example, most people assume that their doctor will prescribe the medication that can cure them the fastest and with the fewest side effects, but that's not always the case. Many physicians have to choose from a limited list of medications, called a drug formulary. The best drug may not be on the list unless it's also the cheapest. For example, if your child has a minor eye infection, many doctors' top choice is Polytrim, a painless antibiotic that's applied once a day. But many health plan formularies only offer a cheaper drug, sodium Sulamyd, that needs to be applied four times a day and stings the eyes. I care whether a four-year-old is in pain.

Of course, when you're sick you want your doctor to level with you about the care you need, even if the health plan won't pay for it. But some insurers actually prohibit doctors from telling their patients the whole truth about the care they need, especially if the health plan won't pay or calls for a cheaper option. In New York we've taken a strong stand against these gag clauses. But most New Yorkers need federal protection. So I urge you to support the Patient's Right-to-Know bill. It will be reintroduced in Congress in January by Greg Ganske (R-Iowa), and is supported by President Clinton.

Continue the Search for Cures

Step three, the most important step of all to protect the quality of health care, is to sustain medical research and the search for new cures. Medical research is in greater danger now than ever before. Managed care companies are slashing payment rates to teaching hospitals and permitting only their most seriously ill patients to seek care there. As a result, teaching hospitals anticipate that they will soon lack the funds to support research faculties. Look ahead to the consequences of reduced support for medical research, especially if you have a family member or friend with Alzheimers, AIDS, juvenile diabetes, cerebral palsy, or another serious illness.

Reducing research is like a farmer eating his seed corn, or a business person selling his assets to finance his operating deficits. We must continue the search for new cures. Right now, if you're seriously ill, the best place to be is in the United States. We are number one in cure rates. We are second to none in the treatment of heart disease. Americans have won 40 Nobel Prizes for medicine. For the sake of our children and grandchildren we must maintain our commitment to our standard of excellence and world leadership in medical research.

I rarely advocate the heavy hand of government regulation. Regulation is costly, it often costs jobs, and certainly in medicine, it retards innovation. But the health insurance industry has failed to regulate itself and to draw a clear line between ethical and unethical cost-cutting. It's a stark contrast with the securities industry—which polices itself so successfully that American financial markets are the envy of the world. Health care is a necessity. If the health industry doesn't begin to self-regulate well enough to allay the growing concerns of consumers and public servants, it will invite the same degree of regulatory oversight as public utilities. ■

NOVEMBER 1996

TRENDLETTER

POLITICAL REPORT

1996 Election Results for Black Candidates to U.S. Congress

		WINNER		DEFEATED	
Alabama	House, 7th	* **Earl Hilliard** (D)	(71%)	Joe Powell (R)	(27%)
California	House, 9th	* **Ronald Dellums** (D)	(77%)	**Deborah Wright** (R)	(18%)
	House, 32nd	* **Julian Dixon** (D)	(83%)	Larry Ardito (R)	(12%)
	House, 35th	* **Maxine Waters** (D)	(86%)	Eric Carlson (R)	(12%)
	House, 37th	* **Juanita McDonald** (D)	(85%)	Michael Voetee (R)	(15%)
Colorado	House, 1st	Diana DeGette (D)	(57%)	**Joe Rogers** (R)	(40%)
Connecticut	House, 5th	James Maloney (D)	(52%)	* **Gary Franks** (R)	(46%)
District of Columbia	At-large	* **Eleanor Holmes Norton** (D)	(90%)	Sprague Simonds (R)	(8%)
Florida	House, 3rd	* **Corrine Brown** (D)	(61%)	Preston Fields (R)	(39%)
	House, 17th	* **Carrie Meek** (D)	(89%)	**Wellington Rolle** (R)	(11%)
	House, 23rd	* **Alcee Hastings** (D)	(73%)	Robert P. Brown (R)	(27%)
Georgia	House, 2nd	* **Sanford Bishop** (D)	(54%)	Darrel Ealum (R)	(46%)
	House, 4th	* **Cynthia McKinney** (D)	(58%)	John Mitnick (R)	(42%)
	House, 5th	* **John Lewis** (D)		Unopposed	
Illinois	House, 1st	* **Bobby Rush** (D)	(85%)	Noel Naughton (R)	(13%)
	House, 2nd	* **Jesse Jackson, Jr.** (D)	(94%)	Frank Stratman (L)	(6%)
	House, 7th	**Danny K. Davis** (D)	(82%)	Randy Borow (R)	(15%)
Indiana	House, 6th	* Dan Burton (R)	(75%)	**Carrie Dillard Tramell** (D)	(23%)
	House, 10th	**Julia Carson** (D)	(53%)	Virginia Blankenbaker (R)	(45%)
Louisiana	House, 2nd	* **William Jefferson** (D)		Unopposed	

		WINNER		DEFEATED	
Maryland	House, 4th	* **Albert Wynn** (D)	(85%)	John Kimble (R)	(15%)
	House, 7th	* **Elijah Cummings** (D)	(83%)	Kenneth Kondner (R)	(17%)
Massachusetts	House, 7th	* Edward Markey (D)	(70%)	**Patricia Long** (R)	(30%)
Michigan	House, 14th	* **John Conyers** (D)	(84%)	William A. Ashe (R)	(14%)
	House, 15th	**Carolyn Kilpatrick** (D)	(88%)	Stephen Hume (R)	(10%)
Mississippi	House, 2nd	* **Bennie Thompson** (D)	(59%)	**Danny Covington** (R)	(38%)
	House, 4th	* Mike Parker (R)	(62%)	**Kevin Antoine** (D)	(36%)
Missouri	House, 1st	* **William Clay** (D)	(70%)	Daniel O'Sullivan (R)	(28%)
New Jersey	House, 10th	* **Donald Payne** (D)	(84%)	**Vanessa Williams** (R)	(15%)
New York	House, 6th	* **Floyd Flake** (D)	(85%)	Jorawar Misir (R)	(15%)
	House, 10th	* **Edolphus Towns** (D)	(91%)	**Amelia Smith-Parker** (R)	(8%)
	House, 11th	* **Major Owens** (D)	(92%)	**Claudette Hayle** (R)	(8%)
	House, 15th	* **Charles Rangel** (D)	(91%)	**Edward Adams** (R)	(5%)
North Carolina	Senate	* Jesse Helms (R)	(53%)	**Harvey Gantt** (D)	(46%)
	House, 1st	* **Eva Clayton** (D)	(66%)	Ted Tyler (R)	(33%)
	House, 12th	* **Melvin Watt** (D)	(71%)	Joeseph Martino (R)	(27%)
Ohio	House, 11th	* **Louis Stokes** (D)	(81%)	James Sykora (R)	(15%)
Oklahoma	House, 4th	* **J.C. Watts** (R)	(58%)	Ed Crocker (D)	(40%)
Pennsylvania	House, 2nd	* **Chaka Fattah** (D)	(88%)	**Larry Murphy** (R)	(12%)
South Carolina	House, 6th	* **James Clyburn** (D)	(68%)	Gary McLeod (R)	(30%)
Tennessee	House, 9th	**Harold Ford, Jr.** (D)	(61%)	**Rod DeBerry** (R)	(37%)
Texas	House, 10th	* Lloyd Doggett (D)	(56%)	**Teresa Doggett** (R)	(41%)
	House, 18th	* **Sheila Jackson-Lee** (D)	(77%)	Larry White (R)	(10%)
	House, 30th	* **Eddie Bernice Johnson** (D)	(55%)	John Hendry (R)	(18%)
Virginia	House, 3rd	* **Robert Scott** (D)	(82%)	**Elise Holland** (R)	(18%)
Virgin Islands	At-large	**Donna Christian Green** (D)	(51%)	* **Victor Frazer** (I)	(49%)

Note: Names in bold are black candidates.

* Indicates incumbents

ECONOMIC REPORT

by Edward Montgomery and Malinda Lindquist

Income Inequality Within the Black Community

Despite some progress in the 1960s and early 1970s, the average household income of African Americans continues to be substantially lower than that of whites. According to the U.S. Census Bureau, on average, income for black households in 1970 was 61 cents for every dollar of income for white households, while in 1995, the ratio was only slightly higher, at 63 cents for every dollar. Not only do blacks make less on average than do whites, they are more likely to be poor; 29.3 percent of black households had incomes below the poverty line in 1995 versus the 11.2 percent of white households below the poverty line.

While black income continues to lag, the income gap between lower and upper income Americans has widened over the past 15 years, raising concern over the possible disappearance of the middle class. College-educated workers have continued to make gains, while less educated workers have seen their real incomes stagnate or decline. These patterns of growing inequality have been evident within the black community as well and point to a growing economic isolation of the poor or underclass.

Since 1970 there has been a steady increase *within the black community* in the share of income going to the top 20 percent of households, rising from 46 percent of all black income in 1970 to 50 percent as of 1995. Interestingly, almost all income gains (93 percent) within this group during this period occurred among the wealthiest 5 percent of black households, namely, those earning more than $79,831. As the share of income of the top 20 percent of blacks grew, the share of the middle and poorest segments of the community declined, with the middle 60 percent of the black population suffering the greatest decline. Their share of income shrank from 51 percent to 47 percent between 1970 and 1995.

It is important to remember that even the richest 5 percent of black households have lower mean incomes than the richest 5 percent of white households ($122,558 and $193,374, respectively), indicating that racial inequality exists at both the upper and the lower ends of the income spectrum. Despite the gains brought about by increased education and the improved employment opportunities that resulted from affirmative action, even the most well-off blacks have not achieved equity. More troublesome for the community as a whole, however, may be the fact that blacks both in the middle and at the lower end are losing ground not only to whites but to their black counterparts, suggesting a need for more effective strategies for improving economic opportunity.

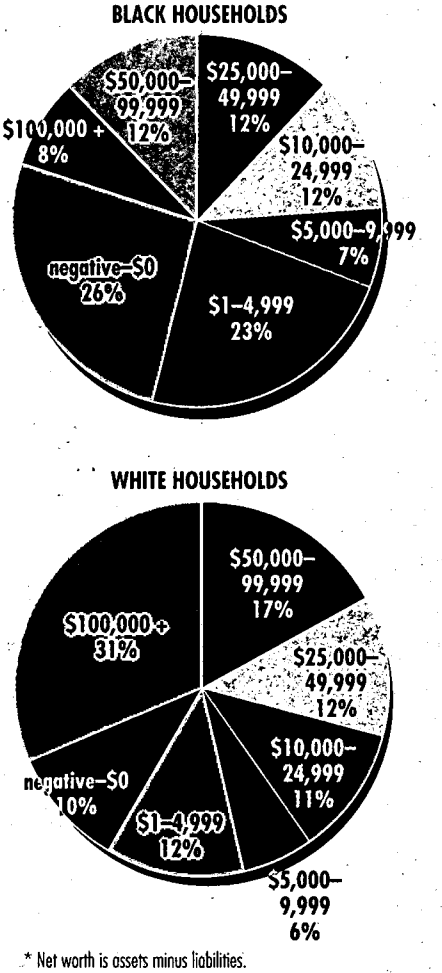
The Black/White Wealth Gap

While income is a key indicator of the extent to which middle class status is being achieved or maintained, so is the level of a household's net worth or wealth, which is defined as the sum of all assets including equity in one's home and car, savings and checking accounts, and the value of any stocks, bonds, or other financial assets minus liabilities. Wealth is an important barometer of middle class status, as it reflects an individual's living standard, ability to send children to college, or potential to save for retirement. While portions of the black community have made strides in achieving middle class status as measured by their income, they lag substantially behind whites in achieving middle class status as measured by wealth.

According to the Census Bureau, the average net worth (wealth) of white households in the United States in 1993 (the most recent year for which data is available) was $109,132, but for black households it was only $28,416. Thus, while the mean black household earns almost two-thirds of the mean white household's income, its net worth is

FIGURE 1

Distribution of Household Net Worth*, 1993



* Net worth is assets minus liabilities.
Source: Unpublished data from Survey on Income and Program Participation, 1993.

about a quarter of the white household's wealth. As seen in Figure 1, the differences in the distribution of net worth between blacks and whites are striking for both the richest and poorest households. Approximately 49 percent of all black households have a net worth of less than $5,000, more than twice the proportion of white households whose net worth is under this amount. Similarly, while the richest 32 percent of black households have a net worth over $25,000, the richest 31 percent of white households have a net worth over $100,000.

For most black and white households, the major source of wealth is the equity in one's home. While 67 percent of whites and 45 percent of black households have equity in their homes, the value of this equity differs dramatically. The median black homeowner has $28,796 in home equity, about 60 percent of the value of the equity held by the median white homeowner ($49,500). Even more striking than the differences in the home equity values are the differences in the levels of black and white financial assets. Less than 30 percent of all black households have a bank checking account, and only 46 percent have a savings account, compared to 48 and 75 percent, respectively, for whites. No more than 10 percent of black households have any other type of financial assets (stocks, savings bonds, IRAs, etc.). The absence of these assets means that many middle income blacks are severely constrained in their ability to finance retirement, children's education, or "rainy day" emergencies.

Paying the Rising Cost of College

The skyrocketing cost of college tuition has prompted President Clinton to propose a $1,500 tuition tax credit and a $10,000 annual college tuition tax deduction. The states of Maryland, Virginia, Michigan, and Texas, to name a few, are considering or have enacted prepaid tuition plans in the hopes of guaranteeing affordable access to their state colleges and universities. While private universities have always been more expensive than public schools, a year of private college now costs the median U.S. household fully 40 percent of its income. With education, especially postsecondary education, increasing in importance, there is concern that the high cost of a college education may soon shut the door to economic opportunity for children from average American families. Given the lower incomes and accumulated wealth of black households, concern over the affordability of higher education is particularly acute.

For many families, a college education will be the second most expensive purchase (after a home) that they make in their lives. According to the College Board Annual Survey of Colleges, the average annual expenditure at a private four-year college for tuition, room and board, and other related expenses is $19,762 and $9,285 at public colleges. It is projected that, if the cost of a college education continues to rise at the 6 percent annual rate seen over the past decade, the parents of a two-year-old will pay up to $24,000 per year at a public university and $50,000 per year at a private school when their child reaches age 18 (in the year 2012).

According to the College Board, while over $50.3 billion in financial aid was available in the 1995-96 school year, only about half of all students receive financial aid, and the vast majority of those who do still end up paying at least part of the cost of their education. Although the prospect of having to save between $100,000 and $200,000 for a child's education is daunting, financial planners offer several tips to make the process less intimidating for parents. First, and perhaps most important, the earlier parents start saving for their child's education, the easier it will be. If they wait until he or she is a teenager applying for school, they lose the advantage of compound interest, which can substantially reduce the amount of personal income they need to set aside. Second, they need not attempt to save the entire cost of college before their child starts school at age 18.

Unfortunately, many black families need most or all of their current income just to make ends meet. A strategy that avoids reducing the household's current standard of living but still allows for savings is to set aside half or more of the raise the parent(s) receive each year. For a worker making $25,000 per year and getting a 3 percent raise ($750), setting aside half or more of the raise would allow them to save between $350 and $750 in the first year. By forgoing a raise just once and putting the $750 a year aside each year at 8 percent interest from the time the child is 2 until age 18, the household would accumulate almost $25,000 in savings.

Over time, if part of each subsequent year's raise were also saved, the accumulated savings would be much greater. This strategy allows the family to minimize the effects of the sacrifice and exploits the old adage—you don't miss what you never had. The key to ensuring that blacks are not locked out of the opportunities afforded by a college degree is to start early and remember that some savings is better than none. ■

New Sports Avenues to College and Fame

Several Programs Are Exposing African Americans to New Academic Opportunities While They Learn Golf, Hockey, Soccer, and Gymnastics

by Frank McCoy

For years, many black youths have honed their skills as basketball, baseball, and football players with hopes of one day going to the pros. But several programs are teaching youngsters to play sports less commonly seen in black communities while stressing academic achievement and social service. And an increasing number of young rising stars in sports such as golf, ice hockey, soccer and gymnastics are demonstrating that athletic scholarships are no longer limited to those with good tackling skills or great jump shots.

Choosing the Back Nine over the Backboard

Despite the recent flurry of interest that Tiger Woods' success on the greens has generated, golf has been providing opportunities for young African Americans for several years now. Since 1984, the Phoenix-based National Minority Junior Golf Scholarship Association (NMJGSA) has exposed black youngsters to the game's fundamentals and raised money to send them to college and graduate school. Founder and president Bill Dickey says the nonprofit organization has provided $300,000 in scholarships to 400 student golfers. Supporters include the Professional Golfers' Association of America, *Black Enterprise* magazine publisher Earl G. Graves, and several corporations.

At present, more than 200 scholarship winners attend college. Although some continue playing, there is no stipulation that they join the college golf team after winning the scholarships. "The goal," says Dickey, "is to teach them the sport and help them get an education." In 1996, the NMJGSA will merge with the National Minority Golf Foundation (Tel. 602-258-7851). John Merchant, the first African American member of the U.S. Golf Association (USGA) executive board has been selected as the new group's president and CEO.

Eddie Payton is director of Jackson State University's golf program, which this year fielded a multinational, 10-man, NCAA Division I golf team, including players from Australia, Ireland, England, Mexico, and New Zealand, as well as African American players. Jackson State, whose team won 8 of 12 tournaments and ranked 27th in the nation last year, is one of 16 historically black colleges and universities with golf teams. Others include Talledega College, Hampton University, and Florida A&M University.

Payton contends that the closed door to pro golf careers that was first cracked open by Calvin Peete and Lee Elder has been opened wider by the success of 20-year-old golf phenomenon Eldrick "Tiger" Woods. Since turning pro earlier this year, Woods has garnered $40 to $60 million in endorsements and won two PGA tournaments.

Tiger's father says his son could swing a golf club before he could walk, was playing on regulation courses at age three, and winning tournaments by age seven. *Sports Illustrated* has written that Tiger, whose father is African American and mother is Thai, grew up in a house where hard work and humility were stressed equally. This ethic has served him well. He attended Stanford University on a full four-year scholarship and maintained a B+ average for two years while leading the golf team and winning two U.S. National Amateur championships—a testament to his intelligence, dedication, and motivation.

Says Payton, "Now Woods can take golf to another level. Tiger shows a lot of minorities who hadn't viewed golf one way or the other that here is a young man who signs for $40 million. It also tells more black parents to look at getting their children into golf at an early age."

Hockey in Harlem

Several nonprofit organizations, like Ice Hockey in Harlem (IHIH), have been working to provide new opportunities to black youngsters while recruiting them to learn how to play ice hockey as an entree to schools and experiences that might otherwise not be available to them. Since 1988, IHIH has trained hundreds of pre-high school youths not only in ice hockey but in academic skills as well. The program's black, Puerto Rican, and Dominican players come from Harlem and the surrounding communities and all take their instruction at Central Park's northern rink. After graduating from IHIH (Tel: 212-722-0044) at about 14 years of age, players have gone on to elite public, parochial, and private high schools and colleges to study and, in some cases, to play hockey as well. Presently, three IHIH graduates attend Trinity Pawling, a prep school in upstate New York, while others have gone on to Skidmore College and the University of Massachusetts at Amherst. Programs similar to Ice Hockey in Harlem are underway in Boston, Albany, and Minneapolis.

In Washington, D.C., the Fort Dupont Ice Hockey Club (Tel: 202-584-5007) has about 80 boys and girls in its program this season. Founder and coach Neal Henderson sees the sport as a vehicle that can broaden a child's vision of the world. One of Henderson's alumni, Ralph Featherstone, is a midshipman at the U.S. Naval Academy and plays for one of the Academy's ice hockey teams.

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Mr. McCoy is the business editor of *Our World News*. Its web site is http://www.ourworldnews.com.

Sports

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Henderson has coached more than 500 young people and says the one thing holding them back is the lack of ice time in a city with only one enclosed ice rink.

The 27-year-old Detroit Hockey Association (DHA) (Tel: 313-990-2529) has nearly 390 youths playing hockey this year, and 90 percent of them are black. Director Marvin Hicks says the DHA has graduates playing in the Ontario Hockey League and the International Hockey League, which feed National Hockey League teams. One DHA alumnus, Akil Adams, is negotiating a jump from the minor leagues to an NHL franchise team, the Tampa Bay Lightning. Hicks, whose DHA teams have played Russian and Finnish youth teams in tournaments, contends "U.S. hockey must prepare to embrace children of color in ice hockey."

A role model for all of these youngsters is Mike Grier, who made his National Hockey League debut in October 1995 as a member of the Edmonton Oilers. Known for devastating body checks, the six-foot one-inch, 220-pound Detroit native and former all-American player for the 1996 NCAA hockey champions, Boston University, made history several years ago. Grier was the first African American (black Canadians have been playing in the NHL since the 1950s) to be drafted by an NHL team.

Soccer Brothers

While the popularity of professional soccer is on the rise, the sport is still viewed as a mostly white suburban or private school game. But Major League Soccer (MLS) spokesman Dan Couremanche says that although the league has no urban outreach programs at present, there are plans to expose more African American youth to soccer. The MLS is connected with Atlanta-based Soccer in the Streets (Tel: 770-477-0354), a nonprofit organization founded in 1989 by Carolyn McKenzie-Edwards, which promotes soccer and academic achievement among youngsters living in public housing and low-income communities in more than 41 cities. The organization has attracted many sponsors, including the Boys and Girls Clubs and the U.S. Soccer Federation, and this year the group received a $50,000 grant from the Soccer Industry Council of America.

If professional soccer does finally take hold in the United States, black players like 25-year-old Cobi Jones, a starting midfielder for the Los Angeles Galaxy Major League Soccer team, will be a major reason for its success. In the past few years, Jones has played in more than 72 international soccer tournaments with the U.S. national team, including the 1996 Olympics and two World Cup series, and he has translated his on-field success into television commercials and appearances in national magazines. Another budding star is Dante Washington, a Columbia, Maryland, native who led the NCAA in scoring while attending Radford University and now plays for MLS's Dallas Burn.

By far the best African American player, and arguably the best MLS player, is Roy Lassiter. In the MLS's inaugural season, Lassiter led the league in scoring and assists. This attracted Italy's Division One team, Genoa, which hired Lassiter to play in its current season. He is only the second American to ever play at that level in Italy.

The success of the more than 20 other African American players on the MLS teams is in turn attracting black fans in the United States. However, there is some irony in the situation. Across the rest of the world, black and "mixed-race" stars have long been commonplace on the Brazilian, Colombian, English, Swedish, Dutch, and Saudi Arabian national teams, and African-descended players often dominate the European professional ranks. Only in the United States are fans used to seeing pro soccer teams on which white players are the stars. Changing this situation will depend on greatly increased visibility of the sport and on programs that nurture young black soccer talent.

A Vault Into the History Books

Every four years during the Olympics, gymnastics—not baseball, basketball or football—becomes one of the most beloved sports in America. While African American gymnasts are still a rarity, Ron Galimore, director of the U.S. Men's gymnastics Program (Tel: 317-237-5050), is convinced that there are more athletes like Dominique Dawes, Jair Lynch, and Chainey Umphrey in the pipeline. Galimore, who was the first African American selected to join a U.S. Olympic Gymnastics team, says that gymnastics will gain more black athletes and fans when more people get past the perception of it as an elite sport. Before this happens, he believes, black youngsters will need to have both role models and greater accessibility. Examples of the latter are foundation- and corporate-sponsored inner city programs such as KidsGym USA in Atlanta, Georgia (Tel: 770-306-0389). KidsGym also has a program in Chicago and another one planned for Tuskegee, Alabama.

As members of the U.S. Olympic gymnastics team, the three athletes mentioned by Galimore were an inspiration to young gymnasts across the country. Women gymnasts usually command most of the attention. But in the 1996 Games, it was the U.S. men who made history, when the appearance of Jair Lynch and Chainey Umphrey marked the first time two black male American Olympic gymnasts performed on the world stage on the same team. Lynch won a silver medal for his performance on the parallel bars. Victory was nothing new to the 1994 Stanford University graduate. In 1992 he was the U.S. parallel bars and high bar national champion.

While skill at basketball, baseball, and football have long been viewed as tickets to college, many black youths may do well to become proficient in golf, hockey, soccer, gymnastics, or other games not usually considered to be "black sports." A high school senior who can drive a golf ball 275 yards down a fairway may have a better chance for a scholarship than a home run specialist. Fortunately, there are numerous programs in operation that are teaching black youngsters these sports, and a whole lot more. ■

Creating Health Care Jobs, But at Low Wages

Most New Employment Generated by the Fast Growing Health Care Industry Will Be Low Skill, Low Wage Jobs

by David C. Ruffin

The perception many Americans have of the nation's health care system has been heavily influenced over the last 40 years by popular television programs—"ER," "St. Elsewhere," "Dr. Kildare." Images of overworked, compassionate physicians applying heroic measures to save the lives of juvenile auto accident victims or mothers with complicated deliveries are common. Emergency rooms in real life can indeed be dramatic places. However, if TV producers were to give us a truer picture of how health care is administered, there would also be far more scenes of nurses assistants wheeling elderly convalescents down nursing home corridors and home-care aides changing the bedpans of homebound cancer patients.

The changes in how and where health care is provided have had a significant impact on the type of jobs being created by the health care industry. The changing shape of health care was a major focus of the Joint Center's November 20 forum on "Job Creation Within Health Industries." The forum was organized by the Joint Center's director of health policy, Bailus Walker, and Senior Research Associate Edward Montgomery. Speakers included Betsy McCaughey-Ross, lieutenant governor of New York; Dr. Kenneth Shine, president of the Institute of Medicine; Dr. Neil Rosenthal, chief of the Division of Occupational Outlook at the U.S. Bureau of Labor Statistics; Peter Nixon, senior policy analyst at the Service Employees International Union; and Baltimore City Councilwoman Helen Holton.

The forum focussed on the health care industry as an engine for job creation. Some speakers observed that because HMOs and other private care providers attend to their profit margins as carefully as they do to the welfare of their patients, cost-cutting measures such as limiting hospital stays are causing a shift from hospital-based care to care in nursing homes and private residences. As the health care industry undergoes this major restructuring, millions of new jobs are being created.

This growth in jobs is especially meaningful for African Americans, since the proportion of black workers in health care is much higher than in the overall workforce. But those who greet the news of expanding health care jobs as a promise of opportunity for minority workers must also recognize that many of the new positions that will be generated by the industry will be at the lower end of the wage scale.

More $6-an-Hour Jobs

The health care industry is generating new jobs at a faster rate than practically any other field. The demand for workers in the healing professions and related occupations is expected to grow as baby boomers age. According to Neil Rosenthal of the Bureau of Labor Statistics, health care jobs grew at a rate of 14 percent from 1983 to 1994. The industry is projected to infuse about 3.1 million new jobs into the economy between 1994 and the year 2005, a growth rate of 18 percent.

The industry employs roughly one of every eleven workers in the country, more people than the construction industry, the auto industry, the steel industry, or the transportation sector. With the disappearance of manufacturing jobs from most urban communities, health care has become a major source of entry-level employment for workers without college degrees. For example, the health services field accounts for 9.9 percent of total employment in St. Louis, 9.1 percent in Detroit, and 7.1 percent in Los Angeles. In Brooklyn, New York, the two largest employers are Kings County Hospital, with a workforce of 6,800, and Brookdale Hospital, with 4,500.

Rosenthal projects that the total number of health care jobs will continue to increase. This will mean new employment opportunities in a broad range of occupations, from high-skilled, high-wage professions such as physician, optometrist, and pharmacist, to low-skilled, low-wage jobs such as orderly and home care aide. While Rosenthal forecasts that job growth in the upper-scale professions will be between 30 and 33 percent, he also predicts that most of the employment opportunities in the industry will occur among the lower-wage jobs.

Most of the health care workforce is made up of nurses, nurse aides, lab technicians, clerical staff, and people in similar occupations, the majority of whom earn low to moderate wages. Peter Nixon of the Service Employees Union said that the average health care worker earns about $22,000 a year, and many work under stressful and hazardous conditions.

Apart from the division of labor, another major change has been in the kinds of institutions that provide care. Twenty years ago, almost two-thirds of all health care jobs were in hospitals according to Nixon. Today, just under half are located in hospitals, and by the year 2005, hospital jobs are expected to drop to a little over one-third. Care today is provided at a vast array of sites including nursing homes, community-based clinics, group homes, and home care agencies.

One of the factors behind this shift is the increasing share of the population who are enrolled in managed-care health plans, which seek to control costs by limiting the use of high-priced services, especially hospital services.

Mr. Ruffin is the editor of *FOCUS*.

Health Jobs

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The continued expansion of managed care is leading to a decline in the number of hospital admissions and shortening the lengths of stay for those who are admitted. This, in turn, is reducing the demand for hospital beds and staff.

"If each bed taken out of the health care system results in the elimination of between three and four workers," said Nixon, "then over one million jobs involving in-patient care could be lost over the next decade." Rosenthal said that many of these jobs will not vanish but will be downgraded as hospitals and HMOs expand their nursing home facilities and shift care from physicians and other well-paid and highly trained professionals to less skilled and lower paid workers. Registered nurses are being moved away from the bedside in favor of licensed practical nurses and home-care providers.

This occupational shift will mean reduced wages in the industry, said Nixon. For example, staff nurses in nursing facilities earn about 9 percent less than their hospital counterparts. Nurses employed by home care agencies earn about 3 percent less. The drop would be even worse for nursing assistants employed in nursing homes, who earn about 20 percent less than their hospital counterparts. Those employed by home-care agencies earn about 14 percent less.

In nursing homes, most patient care is provided by certified nursing assistants who earn an average of $6.72 an hour—poverty-level wages. In home care, a considerable amount of the job growth is in $6.00 an hour nonmedical supportive services—homemaking, food preparation, and transportation jobs.

In addition to a shift in the composition of health industry jobs, there may also be a shift in the geographical location of health care services. Access to services by urban residents could be reduced in an increasingly market-driven health-care system as suburban hospitals and health systems shift more resources to faster growing suburbs.

Softening the Impact of Restructuring

These trends in health-care employment are particularly significant for women and minorities since more than three-quarters of health care workers are women. And while African Americans make up about 11 percent of the overall labor force, they are 16 percent of the hospital workforce and comprise 24 percent of all nursing home employees. During the forum, Samuel Myers, the Roy Wilkins Professor of Human Relations and Social Justice at the University of Minnesota's Humphrey Institute, expressed concern that a "ghettoization" of black health workers was taking place as they are being concentrated in low-end health care jobs.

One way to ameliorate the impact of restructuring in the health care industry is for local and state governments to beef up their support of urban medical centers to ensure their survival. In addition, state and local governments must formulate strategies on how to deal with large scale dislocations of health care workers. For example, those at risk of being laid off should have access to retraining programs and assistance in job search and placement.

Despite the dislocations, policymakers can be optimistic that the burgeoning growth in health care jobs, many paying high wages, will continue for the foreseeable future. But local governments seeking to attract health providers to their jurisdictions as elements of an economic development plan may be disappointed, since the dominance of low-end occupations in the industry will result in uneven economic benefits.

A fuller summary of the issues discussed in the forum will be released in the spring of 1997. ■

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